DHCS
TOBY DOUGLAS
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State of California—Health and Human Services Agency
Department of Health Care Services

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CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9): INITIAL TRANSITION PLAN FOR THE LOW INCOME HEALTH PROGRAM

Dear Ms. Orris, Ms. Gibson, and Ms. Nagle:

Enclosed is the Department of Health Care Services's (DHCS) initial transition plan for the Low Income Health Program (LIHP). As agreed, this document completes the deliverable required by Paragraph 23.a of the Special Terms and Conditions of California's Section 1115 Bridge to Reform Demonstration (11-W-00193/9).

If you or your staff have any questions or need additional information regarding this report, please contact Brian Hansen, Health Reform Advisor, at (916) 440-7418.

Sincerely,

for Toby Douglas
Director

Enclosure

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INITIAL PLAN

Implementing the Affordable Care Act (ACA) in California:

Transitioning the Low Income Health Program to ACA Coverage Options

Special Terms and Conditions of California's §1115 Waiver, Section 23.a

It is estimated that total enrollment in the Low Income Health Program (LIHP) Demonstration will be 450,000 to 500,000 by December 31, 2013. This initial transition plan for the Low Income Health Program enrollees provides the first plan prepared for the Centers for Medicare and Medicaid Services approval in accordance with STC 23.a of California's "Bridge to Reform" §1115 Waiver.

Described within this initial plan are the steps the Department of Health Care Services (DHCS), in collaboration with the local LIHPs, counties, the California Health Benefit Exchange (the Exchange), and stakeholders, will take to coordinate the transition of the LIHP enrollees to a coverage option available under the Affordable Care Act (ACA) without interruption in coverage to the maximum extent possible. This initial plan is the first iteration and serves as a working document that will evolve after August 1, 2012, as more information becomes available and through additional structured stakeholder engagements. This plan will be incrementally revised and DHCS will submit subsequent iterations as appropriate.

Strategies included in the plan address the transition milestones of STC 23.a (Full text of the STCs are included in Appendix A):

- STC 23.a.i and ii: Determine eligibility for all groups for which the State is required or has opted to provide medical assistance and develop a plan to manage the transition to new Medicaid eligibility levels by preliminarily determining new applications for Medicaid eligibility beginning July 2013
- STC 23a.iii: Criteria for provider participation in and means of securing provider agreements for the transition

- STC 23.a.iv: Schedule of implementation activities for transition plan
- STC 23.a.v: Assurance of adequate primary and specialty care providers

This plan's development involved significant guidance and input from stakeholders that included group and individual interviews, as well as public comment sessions with LIHP stakeholders, counties, the §1115 Waiver Stakeholder Advisory Committee, and the Exchange.

STC 23.a.i. and 23.a.ii

Plan for Eligibility Determination and Pre-Enrollment

To facilitate eligibility determination of LIHP enrollees for health coverage options available under the ACA, local LIHPs will inform LIHP enrollees throughout 2013, during the application, redetermination and other in-person encounters, regarding the change in coverage and reasons for requesting information needed for their transition. DHCS will engage the LIHPs on the development of eligibility redetermination procedures for the transition process by issuing written instructions to the LIHPs to ensure statewide consistency in the transition of individuals enrolled in the LIHP to new coverage under Medicaid or the Exchange.

DHCS will work with local LIHPs to establish a plan for the collection of required data elements and use existing LIHP enrollee information for Medicaid and Exchange eligibility determinations, to the extent possible, to facilitate a smooth transition. The data required for the transition will be collected from the enrollees by the LIHPs and will be used by the State or the Exchange to ensure a seamless transition that protects continuity of coverage and care to the greatest extent possible.

The plan will be streamlined and include a simplified and consistent process so LIHP enrollees will transition to Medi-Cal or Exchange health coverage on January 1, 2014.

All LIHP enrollees will be provided with information regarding:

- New program or Exchange eligibility;
- Pre-enrollment;
- Possible changes in health coverage from local LIHPs to Medi-Cal Managed Care Plans or the Exchange; and
- Eligibility for Advance Payments of the Premium Tax Credit (APTC) and/or cost-sharing subsidies from the Exchange.

Outreach and Communication of Eligibility for Medicaid and Exchange

DHCS will develop and partner with local LIHPs, the Exchange and stakeholders on an outreach and communication strategy for the transition of LIHP enrollees to Medicaid or the Exchange. The outreach and communication effort will include general notification of the LIHP transition to enrollees during 2013 and information on any available transition assistance through the Exchange or the counties. DHCS will provide standardized language for LIHPs to use to inform the enrollees about the transition during enrollment and redetermination encounters beginning January 2013. All notifications to enrollees will be prepared in the required threshold languages and in a clear, consumer-friendly and culturally appropriate manner.

Transition Assistance

Throughout the transition, DHCS will make the transition activities, timeline and contact information for the Medi-Cal program and the Exchange available to LIHP enrollees, health plans, advocacy groups, community-based organizations and navigators. Enrollees will be informed regarding how to access transition assistance in all communications in the required threshold languages. Telephone assistance will be available in all languages.

After January 1, 2014, Medi-Cal program support will continue for LIHP enrollees who are Medi-Cal eligible through DHCS' established processes for Medi-Cal eligibility issues and managed care enrollment changes. LIHP enrollees who are eligible for APTC and/or cost-sharing subsidies will receive assistance from the Exchange.

Medi-Cal Managed Care Plan Assignment

To the extent a LIHP enrollee is determined eligible for Medi-Cal, DHCS will coordinate the transition of coverage from LIHPs to Medi-Cal Managed Care Plans or other available Medi-Cal health care delivery options. The activities below are designed to transition enrollees to coverage options available under the ACA without interruption in coverage to the maximum extent possible.

Those counties operating LIHPs that do not currently have Medi-Cal Managed Care Plans (MMCP) available, but are undergoing a transition to Managed Care, are expected to have completed this transition prior to January 1, 2014. If any county does not transition to Managed Care, LIHP enrollees in that county will enter Medi-Cal fee-for-service (FFS). Should this be required, DHCS will provide information in accordance with standard practices to assist these beneficiaries in accessing care.

Plan Assignment

The following plan assignment procedures have been created to maximize continuity of care, plan choice (if available in the local county), and seamless coverage by using an enrollee-centered process. Further, the procedures reflect stakeholder recommendations that plan assignment should focus on retaining a LIHP enrollee's medical home whenever possible.

Plan assignment will be conducted through a process which assigns enrollees to a MMCP based on their most recent LIHP medical home and makes available information on how to change the plan assignment. The assigned MMCP will conduct medical home assignment based on DHCS' provision of current LIHP medical home information. This will facilitate continuity of care during the transition. The MMCP will continue to provide a method for members to change their medical home if so desired, as is current practice.

DHCS will assign members to a plan using the following guidelines:

- If enrollee's LIHP medical home is in a single MMCP network, enrollee will be assigned to the one plan containing the same medical home.
- If enrollee's LIHP medical home is within multiple MMCP networks, default plan assignment will be conducted using an established algorithm which includes measures for quality and availability of traditional and safety net providers to assign a plan that contains the LIHP medical home in the existing network.
- If enrollee's LIHP medical home is not within a MMCP network, default plan assignment will be conducted using an established algorithm which includes measures for quality and availability of traditional and safety net providers.

Communication of Medi-Cal Managed Care Plan Assignment

DHCS will capitalize on experiences from previous transition activities and use existing broker relationships to facilitate communication regarding enrollment and plan assignment. This approach enhances efficiency and minimizes administrative burdens as established processes are used to implement this plan. In addition, building on experience will enable DHCS and broker partners to ensure a smooth transition that meets a wide variety of member needs.

Each LIHP enrollee will be sent written notice no sooner than 90 days prior to January 1, 2014. The notice will state the following information in the required threshold languages:

- The notice will inform LIHP enrollees of the transition into Medi-Cal.

- Identification of the enrollee's current Primary Care Provider (PCP) or Medical Home in the LIHP.
- Identification of the enrollee's plan assignment, to be effective January 1, 2014, based on the enrollee's current medical home or PCP in the LIHP, or default algorithm if the medical home is available in more than one plan.
- The notice will inform the enrollee that s/he will be enrolled, effective January 1, 2014, into this health plan.
- The notice will inform enrollees they will not need to do anything.
- The notice will inform enrollees that they have the right to select an alternate plan, if one is offered in their county, prior to January 1, 2014.
- A packet of information about the available plans and providers (in the LIHP enrollee's county), and instructions about how to change plans, will be provided to all LIHP enrollees with the transition notice.
- Those who wish to change plans can do so through the Medi-Cal managed care enrollment broker, Health Care Options (HCO).

These notices will also inform enrollees of educational information such as HCO presentations available in their county of residence and other rights.

Continuity of Care

For LIHP enrollees who are eligible for Medi-Cal and assigned to a MMCP, the strategies employed below will create protections through the transition, including for those with special transition needs. Medi-Cal beneficiaries enrolled in a MMCP are protected under Welfare and Institutions Code Section 14185, which ensures the timely and efficient processing of authorization requests for drugs, when prescribed for plan enrollees that are covered under the terms of the plan's contract with DHCS and require prior authorization from the plan. Medi-Cal beneficiaries enrolled in a MMCP are also protected under Health and Safety Code Section 1373.96, which states that completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision "c" of that section. These protections for "continuity of care" will continue for this population.

- LIHP provider outreach: DHCS will analyze LIHP provider lists for overlap with the current MMCP network lists. DHCS and MMCPs will conduct targeted outreach to providers who are part of LIHP networks but not currently part of MMCP networks.

- DHCS will receive data listing each enrollee's chosen LIHP medical home for the purpose of plan assignment and MMCP medical home assignment.
- After plan enrollment is complete, DHCS will carry out standard processes to provide MMCPs with information regarding incoming members including the provision of a 12-month claims/encounter history, when available, for the purposes of care coordination and case management.

Rate Setting

Available data on demographic characteristics and health service utilization patterns from the LIHPs will be used in rate setting for Medi-Cal managed care plans. DHCS will evaluate options to address any gaps in data, such as Medi-Cal fee-for-service data or additional demographic data on the previously uninsured MAGI Medi-Cal expansion population. Rates will be developed in an actuarially sound manner, consistent with Welfare and Institutions Code Section 14301.1.

Exchange Plan Selection

LIHP enrollees found eligible for APTC in the Exchange will make their health plan choice via the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS) or other plan selection modalities used by the Exchange.

Information Systems and County Collection of Data Elements

The eligibility determination and plan assignment activities described above are supported through counties and the State enabling the transmission of LIHP enrollee data to new eligibility systems, health plans and the Exchange. An overview of the data related activities during the transition are described below.

Data required for each aspect of the transition will be collected from LIHPs, DHCS, or LIHP enrollees. DHCS will use processes developed and deployed for previous or existing transitions, wherever possible, to maximize administrative efficiencies and will develop new protocols, as warranted. For purposes of the transition, DHCS and LIHPs will obtain necessary written consent from LIHP enrollees, as required, related to enrollment and data sharing. DHCS will provide counties with standard consent language to incorporate into the LIHP enrollment and redetermination processes for any new application or existing recertification occurring on or after January 1, 2013. A method for tracking consent will be developed to protect the privacy of individuals who do not provide consent.

Data Sources Required for Transition shall Include:

- LIHP enrollee's income, household composition and tax filing status.
- LIHP provider listings for Medi-Cal vs. LIHP network analysis.
- Medi-Cal Eligibility Data System (MEDS) records.
- LIHP medical home assignment records.
- Claims/Encounter data housed at UCLA (on DHCS' behalf) for plan assignment, care coordination, and rate setting.
- LIHP enrollee IDs, MEDS Client Index Numbers (CINs) and Social security numbers (SSNs) to match LIHP claims and medical home records to MEDS records, if needed.

Data Transmission Responsibilities:

DHCS is responsible for receiving data transmissions for the transition and finalizing all necessary legal considerations related to data transfer to the Exchange. UCLA has existing secure file transfer protocols and HIPAA Business Associate Agreements that cover the receipt of data from LIHPs and DHCS. Given appropriate approvals and protections, UCLA will adopt responsibility for transmission of LIHP data housed at UCLA and required for the transition, to the extent permissible under HIPAA.

All data and IT processes will be completed on a schedule that supports pre-enrollment activities starting in July 2013.

STC 23.a.iii

Criteria for Provider Participation and Means of Securing Provider Agreements for the Transition

DHCS will apply standard criteria for provider participation in MMCP and, if needed, FFS Medi-Cal. Providers will be required to meet established data collection and reporting capacity requirements in accordance with existing Medi-Cal policies and procedures.

DHCS will ensure available network capacity within plan networks; capacity will be based on the existing contractual standards in the MMCP contracts.

Continuity of care will be provided in the case that a LIHP enrollee will experience a change of provider as a result of the transition in accordance with Health and Safety Code Section

1373.96. DHCS will assess provider networks to determine if other continuity of care protections for transitioning LIHP enrollees will be needed, similar to other DHCS transitions.

STC 23.a.iv.

Schedule of implementation activities

Approximate date ranges for implementation activities are shown below. DHCS will update this timeline as needed throughout the planning process.

January – June 2013

- General transition notification to LIHP enrollees begins
- County-specific assessment of provider network differences between LIHP and MMCP
- Outreach to LIHP providers not in MMCP network begins

July – December 2013

- MAGI-based eligibility determinations of enrollees
- Exchange outreach to potentially-eligible LIHP enrollees
- Medi-Cal Managed Care Plan assignments
- Medi-Cal eligibility and enrollment notification

January 2014

- Post-transition support to LIHPs and enrollees

STC 23.a.v.

Process for Assuring Adequate Primary Care and Specialty Provider Supply

DHCS will assess comparability of LIHP and Medi-Cal provider networks, and will ensure adequate provider supply to maintain compliance with access to care standards after the transition.

- DHCS will receive LIHP provider network listings and will conduct network comparison between LIHP networks and Medi-Cal networks.
- DHCS will conduct outreach to encourage any LIHP providers that are not already participating in the local Medi-Cal network (FFS or Managed Care) to begin participating.
- DHCS will assess network adequacy, using Medi-Cal network data and LIHP enrollment data. DHCS will use aggregate data on use by LIHP enrollees, as available, to inform on past use of services by the enrolled population.

- DHCS will inform MMCPs of the anticipated number of newly assigned members allowing the health plans the opportunity to undertake necessary administrative efforts, including network/contracting negotiations, which may be required to maintain access to care standards and prepare for the transition of newly eligible populations.

Appendix A. Special Terms and Conditions of California's §1115 Waiver, Section 23.a[i]

IV. GENERAL REPORTING REQUIREMENTS

23. Transition Plan. This Demonstration will not be extended by CMS beyond December 31, 2013 for the Medicaid Coverage Expansion and the Health Care Coverage Initiative Demonstration populations. The State is required to prepare, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in these Demonstration populations, including details on how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The State must meet the following transition milestones.

a. **Affordable Care Act Transition Plan** - By July 1, 2012, the State must submit to CMS for review and approval an initial transition plan, consistent with the provisions of the Affordable Care Act for all individuals enrolled in the Demonstration, The plan must outline how the State will begin transition activities beginning July 1, 2013, including:

i. The State shall determine eligibility for coverage for these individuals beginning January 1.2014 under all eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL. To ensure that eligibility for medical assistance is not disrupted for any individual covered who will be eligible under any such eligibility group as of January 1.2014, prior to December 31.2013, the State shall obtain any additional information needed from each individual to determine eligibility under such eligibility groups beginning January 1.2014 and shall make and provide notice to the individual of such determination on or before December 31.2013. In transitioning these individuals from coverage under the waiver to coverage under the State Plan, the State will not require these individuals to submit a new application.

ii. A plan to manage the transition to new Medicaid eligibility levels in 2014 by considering, reviewing, and preliminarily determining new applications for Medicaid eligibility beginning as early as July 1, 2013.

iii. Criteria for provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

iv. The schedule of implementation activities for the State to operationalize the transition plan.

v. The process the State will use to assure adequate primary care and specialty provider supply for the State Plan and Demonstration Populations affected by the Demonstration on December 31, 2013.

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[i] Centers for Medicare and Medicaid Services: Special Terms and Conditions. *California Bridge to Reform Demonstration.* Document Number: 11-W-00193/9.